DEPARTMENT OF HEALTH AND HUSENICES

PRINTED: 08/10/2016 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					OMB NO. 0938-03
	T OF DEFICIENCIES OF DORRECTION	IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		LE CONSTRUCT		(X3) DATE SURVEY COMPLETEO
		495409	B WING				07/28/2016
NAME OF	PROVIOER OR SUPPLIER				STREET AODRES	S. CITY, STATE, ZIP CODE	
				1	15051 HARMON	Y HILLS LANE	
ABINGD	ON HEALTH CARE LL	C	1	f	ABINGDON, W	A 24212	
IX41ID PREFIX TAG	(EACH OEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROV (EACH C	/IDER'S PLAN OF CORREC CORRECTIVE ACTION SHO EFERENCEO TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
F 272 SS=E	survey was conduct 07/28/16. One com the survey. Correctic compliance with 42 Term Care requirem survey/report will foll. The census in this 1: 115 at the time of the consisted of 27 Resi reviews (Residents # and 4 closed record through #24). 483.20(b)(1) COMPF ASSESSMENTS The facility must come a comprehensive, and reproducible assessment of a resident assessment by the State. The assleast the following: Identification and den Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior payschosocial well-bei Physical functioning as	edicare/Medicaid standard ed 07/26/16 through plaint was investigated during ons are required for CFR Part 483 Federal Long ents. The Life Safety Code low. 20 certified bed facility was a survey. The survey sample dent reviews with 23 current to through #20 and 25,26,27) reviews (Residents #21) REHENSIVE duct initially and periodically curate, standardized ment of each resident's lacomprehensive dent's needs, using the instrument (RAI) specified sessment must include at mographic information;	F 00		Corragre Heal defice represent Cent going that regu 272 1.	submission of the Prection does not consement on the part of lith & Rehab Center to ciencies cited within esent deficient pract of Abingdon Health ter. This plan represt g pledge to provide is rendered in accordatory requirements. Comprehensive As resident number 10 section V did not in and location documfor CAA Summary in noted. All resident have the beaffected if section documented with the location for the CAA review of current recomprehensive assisted to encompletion of CAA' Regional MDS Conseducate staff response completion of section including date and information used for the consequence of	estitute of Abingdon that the the report tices on the & Rehab sents our on- quality care dance with all s. esessments for 0, 3, 6 and 15 solude date nentation used is dually ne potential to on V is not ne date and A triggers. A esidents' last esessment will esure accurate 's. esultant will onsible for the on V on location of
(Continence; Disease diagnosis an	·				oaaan adda to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction states in the continued program participation.

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(X6) DATE

TITLE

	RTMENT OF HEALTH ERS FOR MEDICARE	AND HE AN SERVICES			(PRINTED: 08/10/201 FORM APPROVE
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	TIPLE CONSTRUC		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME O	000040500000000	495409	B WING			C 07/28/2016
	F PROVIDER OR SUPPLIER DON HEALTH CARE LL	c			ESS, CITY, STATE, ZIP COD DNY HILLS LANE VA 24212	E
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACI	OVIDER'S PLAN OF CORRE H CORRECTIVE ACTION SHI -REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 272	the additional assess areas triggered by th Data Set (MDS); and	al status; and procedures; anmary information regarding sment performed on the care e completion of the Minimum	F 2	72 4. 5.	MDS Coordinator of will audit 10% of coassessments week and 10% audit of coassessments mont months. Any discrebe addressed promfindings will be reproducitly Assurance review and further findings. Correction date Se 2016	omprehensive kly x 1month completed thly x 2 epancies will nptly and orted to committee for analysis of
	by: Based on staff intervireview, the facility sta comprehensive MDS	is not met as evidenced iew and clinical record ff failed to ensure accurate (minimum data set) 27 Residents, Residents				
	The findings included.					
	include the location of section V (care area a	he facility staff failed to the CAA documentation in ssessment (CAA) dents significant change in				

status MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/11/16.

Resident #10 was admitted to the facility 01/01/15. Diagnoses included, but were not limited to, dementia, anemia, hypertension, enlarged prostate, restless leg syndrome, and

EvenI ID SOHX11

Facility ID: VA0406

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		AND HU AN SERVICES			PRINTED: 08/10/201 FORM APPROVE
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	ł	TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495409	B WING		C
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY STATE, ZIP CODE	1 07/28/2016
ABING	OON HEALTH CARE LL			15051 HARMONY HILLS LANE ABINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 272	Continued From paganxiety.	ne 2	F 27	2	
	significant change in	patterns) of the Residents status MDS assessment /16 had a summary score of 5 points.			Ī
	Location and Date of	section V of this part "3. Indicate in the CAA Documentation columnated to the CAA can be			
	CAA documentation" documented "CAA W triggered areas of visit ADL functional/rehab incontinence/indwellin status, pressure ulcer and pain and had doc	S (worksheet)" for the ual function, communication, potential, urinary g catheter, falls, nutritional, psychotropic drug use, umented the date of ocation(s) regarding the		Refer to page 1	
ı	about the missing doc MDS nurse verbalized had checked the CAA unable to find the supp	porting documentation.			
ı	missing MDS informati	m was made aware of the on during meetings with (27/16 and on 07/28/16.			
1	No additional information	on regarding this issue was team prior to the exit			-

2. The facility staff failed to document location

conference.

Event ID SOHX11

Facility ID VA0406

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DEPARTMENT OF HEALTH AND HE AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MED	ICARE (MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	s (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495409	B WING		C 07/29/2016
NAME OF PROVIDER OR SU	PPLIER		'	STREET ADDRESS CITY STATE, ZIP CODE	07/28/2016
ABINGDON HEALTH C	ARE LLC			15051 HARMONY HILLS LANE ABINGDON, VA 24212	
PREFIX (EACH DEF	ICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
Section V of the annual Mill with an assess 11/17/15 for F The clinical ref 7/26/16 and 7 to the facility of 7/14/16 with dimited to unsign pneumonitis, subjected the disorder hypokalemia, syndrome, and gastroesophale Resident #3's reference date resident with a of 15 in Section A review of the	ne inform the CAA DS (mini- isment re Resident Resident 27/16. on 12/7/16. on 12/7/16 liagnose becified i status eper, osteo sleep aperile annual fe (ARD) i cognitive n C0500	nation used to complete (Care Area Assessment) for mum data set) assessment eference date (ARD) of #3. Resident #3 was reviewed Resident #3 was admitted 12 and readmitted on s that included but not intellectual disabilities, bilepticus, dysphagia, porosis (age related), prea, restless legs teoarthritis, and ux disease. MDS with an assessment of 11/17/15 coded the re summary score of 13 out	F 27	2 Refer to Page 1	
areas in Section Urinary Incontion Falls, Nutrition Psychotropic Distriggered areas Iocation and date column for these	on V: AD nence a al Status Drug Use s there wate under se trigge ts failed	L Functional/Rehabilitation, and Indwelling Catheter, s. Pressure Ulcer, e. and Pain. For the vas no documented or the Location and Date red areas. A review of the to reveal a location and he clinical record.			
above finding o surveyor inform at 10:00 a.m. o	n 7/26/1 ned regis f the abo	the MDS staff of the 6 at 3:40 p.m. The stered nurse #4 on 7/27/16 ove concern regarding no ed in Section V CAA and			

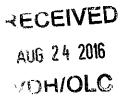
FORM CMS-2567(02-99) Previous Versions Obsolele

no evidence on the CAA worksheets to support the triggered items in Section V. R.N. #4 stated

Event ID. SOHX11

Facility ID VA0406

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		I AND HUILL IN SERVICES 8 MEDICAID SERVICES		(FORM APPROVE	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495409	B WING		C 07/28/2016	
NAME OF	PROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CO		
ABINGD	OON HEALTH CARE LL	.c		15051 HARMONY HILLS LANE ABINGDON, VA 24212		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
F 272	Continued From page	ge 4	F 27	72		
	documentation of da	orrect. There was no ate or location on the CAA ction V that contained riggers.				
		ed the administrative staff of on 7/27/16 at 3:50 p.m.				
	No further information	on was provided prior to the /28/16.				
	and date of the information Section V of the CAA the admission MDS	assessment reference date		Refer to Pa	ge 1	
	and readmitted 2/13/ included but not limite schizophrenia, chron disease, acute kidner mellitus, hypertensive	nitted to the facility 11/16/15 16 with diagnoses that ed to diastolic heart failure, ic obstructive pulmonary y failure, Type 1 diabetes e chronic kidney disease ie 4, hyperlipidemia, urinary tract infection.				
!	(MDS) assessment w reference date (ARD)	of 11/23/15 assessed the oterview for mental status				
ı	revealed Resident #6	sion MDS referenced above triggered for the following DL Functional/Rehabilitation,				

Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, Psychotropic Drug

Eveni ID SDHX11

Facility ID VA0406

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

PRINTED: 08/10/2016 FORM APPROVED

			& MEDICAID SERVICES			OMB	NO. 0938-039
	STATEMENT OF AND PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION ING	(X3)	DATE SURVEY COMPLETED
			495409	8 WING			C 07/28/2016
İ	NAME OF PRO	VIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP	CODE	01120/2010
İ	ABINGDON	HEALTH CARE LL	.c		15051 HARMONY HILLS LANE		
i					ABINGDON, VA 24212		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE
<u> </u>	Us trig loc cold CA date The about the the doc wor informat 4. The section of the	gered areas thereation and date unumn for these trig A worksheets faile for information as surveyor informed recorded and the content of the	Community Referral. For the e was no documented ider the Location and Date igered areas. A review of the ed to reveal a location and in the clinical record. ed the MDS staff of the 6/16 at 3:40 p.m. The egistered nurse #4 on 7/27/16 above concern regarding notented in Section V CAA and CAA worksheets to support a Section V. R.N. #4 stated rect. There was note or location on the CAA tion V that contained ggers. ed the administrative staff of 17/27/16 at 3:50 p.m.	F 27			
	The services recording to the services recording to the services reads reads	d on 7/27/16 and admitted to the fa- mitted 12/15/15 w	d Resident #15's clinical 7/28/16. Resident #15 cility 2/18/13 and ith diagnoses that included stage renal disease,				

dependence on renal dialysis, schizoaffective

CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495409	B. WING		C 07/28/2016
İ	PROVIDER OR SUPPLIER	.c		STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI IEACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	hypertensive chronic dysphagia, hypothyr reflux disease, and a Resident #15's signiful minimum data set (Massessment reference assessed the reside mental status (BIMS). A review of the signiful MDS referenced about the folloding periodic	e, major depressive disorder, c kidney disease stage 5, roidism, gastroesophageal unspecified psychosis. ficant change in assessment MDS) assessment with an ce date (ARD) of 12/22/15 nt with a brief interview for) as 11 out of 15. ficant change in assessment ove revealed Resident #15 wing areas in Section V: oss/Dementia, ADL ation, Urinary Incontinence of the decision was made um. Section V CAA on was present for the gnition, and mood; however, of ADL, Urinary incontinence, our Ulcer and Psychotropic dision made to care plan and did not reveal the date or ince in the clinical record oport the triggered areas. A rksheets failed to reveal a information in the clinical did the MDS staff of the date correct. There was note or location on the CAA	F 27	Refer to Page 1	

information for the triggers.

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Facility ID: VA0406

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DEPARTMENT OF HEALTH AND HE, IAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2016 FORM APPROVED OMB NO. 0938-0391

STATEME	AT OF OFFICIENCIES	W. BBerness				<u> </u>
	NT OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCT		(X3) OATE SURVEY COMPLETEO
		495409	B. WING			C 07/29/2046
NAME OF	PROVIOER OR SUPPLIER			STREET AOORE	SS. CITY, STATE, ZIP COOE	07/28/2016
A DIMO			į		NY HILLS LANE	
ADING	DON HEALTH CARE L	LC	ļ	ABINGDON, \		
(X4) ID	SUMMARY STA	ATEMENT OF OFFICIENCIES	10		OVIOER'S PLAN OF CORRECTION	
PREFIX TAG	(EACH OEFICIENC)	Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	PREFIX TAG	(EACH	CORRECTIVE ACTION SHOUL(REFERENCEO TO THE APPROF OEFICIENCY)	D BE COMPLETION
F 272	Continued From pa	ge 7	F 27	2		
	The surveyor inform the above concern	ned the administrative staff of on 7/28/16 at 10:40 a.m.	. –	-		
	exit conference on 7					
F 278	483.20(g) - (j) ASSE	SSMENT	F 27	B 278		
SS≃E	ACCURACY/COOR	DINATION/CERTIFIED		1.	Resident #12 ARD 6	122146
	The assessment muresident's status.	ust accurately reflect the			modified to reflect ba Resident #13 ARD 7, modified to reflect PA	thing. /15/16
	A registered nurse n each assessment wi participation of healt	nust conduct or coordinate th the appropriate h professionals.			coding. Resident #17 4/28/16 modified to re bathing and PASSR. #4 ARD 6/30/16 mod	' ARD eflect Resident
	A registered nurse massessment is comp	nust sign and certify that the leted.			reflect height and bat Resident #10 ARD 6/ modified to reflect hei	hing. 14/16
	Each individual who assessment must sig that portion of the as	completes a portion of the gn and certify the accuracy of sessment.			Resident #19 ARD 6/ modified to reflect bat Resident #1 ARD 7/1	29/16 thing. 7/16
	willfully and knowingl	Medicaid, an individual who y certifies a material and			modified to reflect bat Resident #20 ARD 7/2 modified to reflect bat	21/16 was
	subject to a civil mon \$1,000 for each asse willfully and knowingly to certify a material a	esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each		2.	All resident have the post affected by inaccurof PASSR, Height, and These are sections A. Assessments for past will be audited in these	potential to rate coding od Bathing. , K, and G. t 30 days
;	assessment.	does not constitute a		3.	for accuracy. MDS Regional Consu educat MDS staff resp for completion of secti and G.	onsible
_	This REQUIREMENT	is not met as evidenced				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PR)NTED: 08/10/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A BUILDING_ 495409 B WING 07/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE 15051 HARMONY HILLS LANE ABINGDON HEALTH CARE LLC ABINGDON, VA 24212 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 278 Continued From page 8 F 278 4. MDS Coordinator or designee will audit 10% of assessments Based on staff interview and clinical record, the weekly x 1 month and monthly facility staff failed to ensure an accurate and x 2 months to ensure accurate complete Minimum Data Set (MDS) for 8 of 27 coding of sections A, K, and G. residents in the survey sample (Residents ' #12, Any discrepancies will be 13, 17, 4, 10, 19, 20 and 1). addressed promptly and findings will be reported to Quality The findings included: Assurance Committee for review The facility staff failed to correctly code and further analysis and findings. bathing on the MDS (Minimum Data Set) for 5. Correction date September 12. Resident #12. 2016 Resident #12 was readmitted to the facility on 3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure. end-stage kidney disease, diabetes, depression, dysphagia, sleep apnea and gastrostomy. The resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene. The surveyor conducted a review Resident #12 ' s clinical record on 7/27/16. The surveyor noted that on the MDS with an ARD date of 6/23/16. under Section G 0120 Bathing, the resident was coded for Self-Performance as an "8" and

entire 7-day period. "

Support Provided as an "8" also. In this area, the code of "8" for Self-Performance stood for "Activity itself did not occur or family and/or non-facility staff provided 100% of the time for that activity over the entire 7-day period." For Support Provided, the "8" code stood for "ADL (Activities of Daily Living) activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the

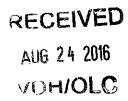
DEPARTMENT OF HE	ALTH AND HUMAN SERVICES		(PRINTED: 08/10/2016 FORM APPROVED
	CARE & MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	(X2) MUL A BUILD	LTIPLE CONSTRUCTION DING	(X3) OATE SURVEY COMPLETEO
	495409	B WING		C 07/20/2040
NAME OF PROVIOER OR SUP	PLIER		STREET AODRESS, CITY STATE, ZIP COOE	07/28/2016
ABINGDON HEALTH CA	BELLC	1	15051 HARMONY HILLS LANE	
ADMODOR HEALTH CA	RE LLO	İ	ABINGDON, VA 24212	
PREFIX (EACH DEFIC	RY STATEMENT OF OEFICIENCIES JENCY MUST BE PRECEOEO BY FULL (OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECT	LD BE COMPLETION
F 278 Continued Fro	m page 9	F 2	78	
documented fil 8:45 am. The me pull up som That may be in At 10:30 on 7/2 returned to the that pulled this page to obtain area on the MD On 7/27/16 at 3 nursing, assista	7/16, the MDS Corporate Nurse surveyor and stated, "The nurse for the MDSdid not refresh the the updated information for this		Def	
No further inforr	mation was provided to the othe exit conference on 7/28/16.		Refer to Page 8	
Preadmission Si (PASRR) on the Resident #13. Resident #13 wa 3/30/16 with the limited to blood of Parkinson 's Dis	staff failed to correctly code the creening and Resident Review MDS (Minimum Data Set) for as readmitted to the facility on following diagnoses of, but not clot, thyroid disorder, dementia, lease, seizures, respiratory all hemorrhage, tracheostomy			

gastrostomy and chronic pain. The resident was coded, on the MDS (an assessment protocol) with an ARD (Assessment Reference Date) of 7/15/16 as having short and long term memory loss. Resident #13 was also coded as being severely impaired to make daily decisions. The resident requires extensive assistance with 2 or more staff members for dressing and personal hygiene and was totally dependent on staff for

Event IO: SOHX11

Facility IO: VA0406

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		AND HUMAN SERVICES MEDICAID SERVICES		(PRINTED: 08/10/2016 FORM APPROVED
1			7		OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
			}		С
		495409	B WING		07/28/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	0772072010
ARINGO	ON HEALTH CARE LL	C		15051 HARMONY HILLS LANE	
ADINGD	ON HEALTH CARE LL		i	ABINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT	JLD BE COMPLETION
F 278	Continued From page bathing.	ge 10	F 2	78	
	by the surveyor on 7 surveyor on the MDs under Section A with and 1510, the PSAR coded with dashes in The MDS Corporate	Nurse was notified of the			
	above documented findings on 7/27/16 at 5:20 pm by the surveyor. The MDS Corporate Nurse stated, "Those shouldn't be in there. I educated the one that did that yesterday."				
	of nursing, assistant corporate nurse, corp	m, the administrator, director director of nursing, MDS porate wound care specialist specialists were notified of ed findings.		Refer to Page	8
		information provided to the exit conference on 7/28/16.			
Į	Preadmission Screen	failed to correctly code the ing and Resident Review on the MDS (Minimum			

Data Set) for Resident #17.

Resident #17 was admitted to the facility on 4/20/16 with the following diagnoses of, but not limited to end stage renal disease, dialysis, diabetes, thyroid disorder and bacterial pneumonia. The resident was coded, on the MDS (an assessment protocol) with an ARD (Assessment Reference Date) of 4/27/16 as having a BIMS (Brief Interview for Mental Status)

score of 15 out of a possible score of 15.

Resident #17 required limited assistance of 1staff

EvenI IO: SOHX11

Facility ID: VA0406

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		I AND HÜMAN SERVICES 8 MEDICAID SERVICES		*	FORM APPROVED OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495409	B WING		C 07/28/2016
NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
ABING	OON HEALTH CARE LL	.c		15051 HARMONY HILLS LANE ABINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 278	Continued From pagmember for dressing	ge 1 1 g and personal hygiene.	F 27	78	
	by the surveyor on 7 surveyor on the MDs under Section A, que the PSARR screenir dashes in the boxes was incorrectly code Performance and Suthe resident. In this Self-Performance sto occur or family and/o 100% of the time for 7-day period. "For code stood for "ADI activity itself did not conn-facility staff prov for that activity over the MDS Corporate."	area, the code of "8" for code for "Activity itself did not cor non-facility staff provided that activity over the entire Support Provided, the "8" (Activities of Daily Living) occur or family and/or ided care 100% of the time the entire 7-day period."		Refer to Pa	age 8
	above documented fir pm by the surveyor, stated, "It is wrong." On 7/28/16 at 3:15 pr of nursing, assistant of	ndings on 7/28/16 at 1:30 The MDS Corporate Nurse			
	and clinical services s the above documente There was no further	specialists were notified of			

4. The facility staff failed to ensure Resident #4's significant change in assessment minimum data set (MDS) assessment with an ARD date of

6/30/16 was accurate. Section G Bathing had dash marks recorded for self-performance and

DEPARTMENT	OF HEALTH AND H	(ÚwAN SERVICES
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PRINTED: 08/10/2016 FORM APPROVED OMB NO. 0938-0391

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		495409	B WING		C 07/28/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ABINGE	ON HEALTH CARE LL	_C		15051 HARMONY HILLS LANE	
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F 278	Continued From page	ge 12	F 2	78	
		Section K had a dash mark for	, 2		
	7/26/16 and 7/27/16 to the facility 10/3/13 but not limited to Alz dysphagia, gastroes glaucoma, atherosci	of Resident #4 was reviewed Resident #4 was admitted with diagnoses that included heimer's disease, anxiety, ophageal reflux disease, erotic heart disease, eral vascular disease, and athic neuropathy.			
	with an assessment 6/30/16 assessed the summary score of 10 Summary Score. Further status and more spetthat there were "dash"	d B. Support Provided.		Refer to Page 8	
	reviewed for the 7 da	(activities of daily living) were y look back period. There baths on the electronic			
	(MDS) registered nur. a.m. concerning the concerning the concerning the concerning the concerning the concerning the concerning the concerning to the concerning term of the concerning	ths. She stated the paper locked up in the manager's			

FORM CMS-2567(02-99) Previous Versions Obsolete

EvenI IO: SOHX1t

Facility ID: VA0406

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DEPARTMENT OF HEALTH AND HUWAN SERVICES PRINTED: 08/10/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING_ 495409 B. WING 07/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON HEALTH CARE LLC ABINGDON, VA 24212 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 Continued From page 13 F 278 in June 2016. The surveyor questioned the dash marks for height in Section K and why the height wasn't obtained. R.N. #2 stated Resident #4 was on comfort care and obtaining the height might have been uncomfortable for her. A review of the assignment sheet for Resident #4's unit revealed baths/showers were given 6/2/16, 6/7/16, 6/10/16, 6/14/16, 6/17/16, 6/21/16, 6/24/16, 6/25/16, and 6/29/16. The look back period was 6/24/16 through 6/30/16. Resident #4 received three showers/baths during this time. Refer to Page 8 The surveyor interviewed R.N. #4 after reviewing the bath record and stated the facility needed to work on the process for documentation. The surveyor informed the administrative staff of the above finding on 7/27/16 at 3.50 p.m. No further information was provided prior to the exit conference on 7/28/16. 5. For Resident #10, the facility staff failed to

Resident #10 was admitted to the facility 01/01/15. Diagnoses included, but were not limited to, dementia, anemia, hypertension, enlarged prostate, restless leg syndrome, and anxiety.

document the Residents height on a quarterly MDS (minimum data set) assessment.

Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD of 06/14/16 had a summary score of 7 out of a possible 15 points. Section K0200 (height/weight) had a dash in the boxes that should have

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		(,	PRINTED: 08/10/2016
		& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
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	surveyor interviewed regarding the missin MDS and the electro verbalized to the sur documented in the cold and another heig obtained. The administrative st missing height in a mon 07/28/16 at approvided the conference.	oximately 1:25 p.m. the d RN (registered nurse) #2 g height. After reviewing the onic clinical record RN #2 veyor that the height (70") linical record was over a year that should have been that were notified of the neeting with the survey team ximately 3:15 p.m. In regarding the missing to the surveyor prior to the the facility staff coded the	F 27	Refer to Page 8	
	occur) on the Resider status assessment. Resident #19 was add 08/28/15. Diagnoses limited to, dementia, odiabetes, anemia, residepressive disorder, a Section C (cognitive paignificant change in sARD (assessment refined a summary score points. Indicating the F	included, but were not chronic kidney disease,			

not occur.

coded 8/8 for bathing indicating the activity did

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		I AND HUMAN SERVICES		(,	PRINTED: 08/10/2010 FORM APPROVED
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NAME OF	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/20/2010
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F 278	Continued From page	ge 15	F 2	78	
	07/28/16 at approximum 19 verbalized to the her 2 baths a week a sponge bath on the On 07/28/16 at approximately surveyor interviewed nurse) #6 regarding MDS assessment. Land stated I think the on the shower sheet system. LPN #6 ther access to the shower				
	incorrect documentar	taff were notified of the tion on the MDS regarding eting with the survey team on nately 3:15 p.m.		Refer to Pag	e 8
	No further information provided to the surve conference.	n regarding this issue was by team prior to the exit			

complete.

7. For Resident #1, the facility staff failed to ensure the MDS assessment was accurate and

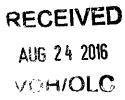
Resident #1 was admitted to the facility on 07/24/16. Diagnoses included but not limited to hypertension, anxiety, anemia, stroke, liver disease, schizoaffective bipolar type, and arthritis.

The most recent MDS with an ARD (assessment reference date) of 7/17/16, resident #1 was coded an 8 under self-performance and 8 under support provided. An 8 is the code for ADL (activities of daily living). The coding indicated that the ADL activity did not occur or family and/ or non-facility

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Facility ID: VAD406

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2016 FORM APPROVED OMB NO. 0938-0391

CLIVIE	EKS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	!	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			1	15051 HARMONY HILLS LANE	<i>y</i> L
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F 278	activity over a 7 day is coded to indicate Resident #1 's bath had occurred during The surveyor spoke 7/27/16 at approximate coding on the MDS.	ge 16 are 100% of the time for that period. Under support the 8 that no support was provided. ing record indicted bathing the 7 day look back period. with the MDS coordinator on ately 11:00 am, regarding the The MDS coordinator stated, tical nurse) #6 regarding the	F2	78	
	coding status on the reviewed the MDS a documenting the bat not marking it in the for the conversion ar assessment."	MDS assessment. LPN #6 nd stated I think they are hs on the shower sheets but system. RN #8 was present nd said "we didn't have an		Refer to Pa	ge 8
	assessment was disc the facility's administration during a survey team of 7/28/16. No further	for Resident #1's MDS cussed for a final time with rator and director of nursing, meeting, on the afternoon information was provided to to the inaccurate MDS.			
		the facility staff failed to essment was accurate and			
	07/14/16. Diagnoses	mitted to the facility on included but not limited to stroke, diabetes, renal			
	reference date) of 7/2	with an ARD (assessment 1/16, for Resident #20, was -performance and 8 under			

support provided. An 8 is the code for ADL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2016 FORM APPROVED OMB NO. 0938-0391

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		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRI		(X3) DATE SU COMPLE	JRVEY
			495409	B WING			07/28/	2016
ļ	NAME OF	PROVIDER OR SUPPLIER			STREET ADD	RESS CITY STATE ZIP CODE	1 017407	
Ì	15010		_			MONY HILLS LANE		
l	ABING	OON HEALTH CARE LL	.C					
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	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOU SS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) PMPLETION OATE
	F 278	activity did not occur staff provided the ca activity over a 7 day	ge 17 ing), indicating that the ADL r or family and/ or non- facility are 100% of the time for that period. For the 8 under licated that no support was	F 27	'8	Refer to Page	e 8	
		had occurred during The surveyor spoke 7/27/16 at approxima coding on the MDS. (licensed practical nuand stated, "I think baths on the shower the system." RN (R	ning record revealed bathing the 7 day look back period. with the MDS coordinator on ately 11:00 am, regarding the The MDS coordinator LPN urse) #6 reviewed the MDS they are documenting the sheets but not marking it in tegistered Nurse) #8 was ersion and said "we didn't"					
	SS=D	assessment was disc the facility's administr during a survey team of 7/28/16. No further the surveyor related to 483.20(d), 483.20(k)(COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE plan to to develop, review and comprehensive plan to The facility must developlan for each resident objectives and timetable medical, nursing, and	CARE PLANS results of the assessment d revise the resident's	F 279	279 1.	Resident #5 care plan reflect dental. All residents are at risk incomplete comprehent plan development. Comprehensive Asses and care plans comple past 30 days will be au accuracy.	for sive care sments ted in the	

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EvenI ID: SOHX11

Facility ID: VA0406

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB N	O. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) D	ATE SURVEY DMPLETED
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS CITY, STATE, ZIP CO	DE	
ABINGDO	N HEALTH CARE LI	.c		15051 HARMONY HILLS LANE ABINGDON, VA 24212		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) CÓMPLETION OATE
F 070						· · · · · · · · · · · · · · · · · · ·

F 279 Continued From page 18

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility staff failed to develop a CCP (comprehensive care plan) for 1 of 27 Residents, Resident #5.

The Findings Included:

For Resident #5 the facility staff failed to develop a CCP for dental.

Resident #5 was admitted to the facility 01/09/13. Diagnoses included, but were not limited to, dementia with behavior disturbances, hypertension, constipation, anxiety, and dysphagia.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/28/15 had a documented summary score of 9 out of a possible 15 points. Section L (oral/dental status) was coded to indicate the Resident had no natural teeth and was edentulous. Section V (care area assessment summary) had triggered for the area of dental care and the staff had

F 279

- Regional MDS Consultant educated MDS staff regarding development of comprehensive care plan.
- 4. MDS Coordinator or designee Will audit 10% of comprehensive care plans weekly x 1 month and monthly x 2 months to ensure care areas are appropriately care planned. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance Committee for review and further analysis and findings.
- 5. Correction date September 12, 2016

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DEPARTMENT OF HEALTH AND HU...AN SERVICES PRINTED: 08/10/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO PLAN OF CORRECTION IOENTIFICATION NUMBER A BUILOING_ COMPLETEO 495409 B WING 07/28/2016 NAME OF PROVIOER OR SUPPLIER STREET AOORESS. CITY, STATE, ZIP COOE 15051 HARMONY HILLS LANE ABINGDON HEALTH CARE LLC ABINGDON, VA 24212 SUMMARY STATEMENT OF OFFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION iO IX5| COMPLETION (EACH OFFICIENCY MUST BE PRECEOED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULO BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE TAG OATE OEFICIENCY) F 279 Continued From page 19 F 279 Refer to Page 18 indicated they would develop a CCP for dental. When reviewing the CCP the surveyor was unable to locate where the staff had care planned dental. On 07/27/16 at approximately 9:10 a.m. the surveyor reviewed the MDS and CCP with RN (registered nurse) #2. After reviewing the MDS and CCP RN #2 verbalized to the surveyor that the area of dental had not been care planned. The administrative staff were notified of the missing dental care plan during meetings with the survey team on 07/27/16 at 3:45 p.m. and on 07/28/16 at 3:15 p.m. No further information regarding the missing care

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP

prior to the exit conference.

plan for dental was provided to the survey team.

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's

F 280

280

- Care plan for resident #12 updated to reflect fall noted on 7/22/16.
- Any resident has the potential to be affected if care plan is not updated with fall occurrences and interventions necessary to reduce risk of future falls.
- DON or designee to educate licensed nursing staff on updating care plans for falls and intervention.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PR(NTED: 08/10/2016 FORM APPROVED OMB NO: 0938-0391

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ł	PROVIDER OR SUPPLIER ON HEALTH CARE LL	c		1505		S. CITY STATE ZIP CODE (HILLS LANE) 24212	07/28/2016
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	and revised by a tea each assessment. This REQUIREMEN' by: Based on staff intenreview, the facility stacomprehensive care residents (Resident: The findings included Resident #12 was rea 3/16/16 with the follow limited to irregular he end-stage kidney dised dysphagia, sleep apnresident was coded of (Assessment Protoco BIMS (Brief Interview 7 out of a possible sowas also coded as red	and periodically reviewed am of qualified persons after T is not met as evidenced view and clinical record aff failed to revise a plan (CCP) for 1 of 27 #12).	F 28	30		NSG Manager or de audit 10% of care pl. 1 month then10% m months to ensure careflective of fall updaintervention. Any dis will be addressed profindings will be repor Quality Assurance or review and further ar findings. Correction date Sept 2016	ans weekly x onthly x 2 ire plans are ites with crepancies omptly and ited to ommittee for nalysis of
t r (r 	by the surveyor on 7/2 nursing note dated an 1:15 pm) which stated esident room by CNA Assistant) reporting re entering resident room	Resident #12 was reviewed 27/16. The surveyor noted a d timed for 7/22/16 at 1315 d, "Summoned to the Certified Nurse's sident on the floor upon noted resident laying on de bed on her left side					

resident stated was getting up and fell resident assessed for injury no noted injury ... "

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2016 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		495409	B WING		07/28/2016
	PROVIDER OR SUPPLIER ON HEALTH CARE LI	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212	
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F 280	Continued From pa	ge 21	F 2	280	
	was also reviewed I noted that the last r plan for falls was da by the facility 's MD Unit Manager #1 wadocumented finding	as notified of the above s on 7/27/16 at 5:40 pm by			
	the surveyor. Unit Manager #1 stated, "I will look into this for you. The QA (Quality Assurance) nurse revises all the care plans."			Refer to Pag	e 20
	Manager #1 came in stated to the survey resident(name	eximately 1:30 pm, Unit not the conference room and or that the care plan for of resident) had not been that had occurred on 7/22/16.			
	of nursing, assistant nurse, corporate wo	om, the administrator, director nursing, MDS corporate und care specialist and cialists were notified of the findings.			
	conference room an she had checked int	ctor of nursing came into the d stated to the surveyor that o this matter and the nurse " are plan" to include the			
	surveyor prior to the	n was provided to the exit conference on 7/28/16. ARE/SERVICES FOR ING	F 30		
		receive and the facility must ry care and services to attain		Please see next	page

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
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NAM	E OF PRDVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 07/20/2010
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PRE	FIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETIO
F:	mental, and psycho-	est practicable physical,	F 30	9 F 309 Provide care/serv Highest Well Being	i c es for
	by: Based on observation document review, and facility staff failed to publishest practicable were	s #5, #10, #12, and #15.		 LPN #3 received 1:1 eduction regarding contents of state to contact pharmacy if un can be cut or broken to old dose. Physician for Reside notified that resident had Buspar on 5/14/16 evenin negative outcome to resident. 	box and need sure if tablet otain correct ent #5 was not received g shift. No
	administer the physic buspar as ordered. Resident #5 was adm Diagnoses included, t dementia with behavio			The attending physician fo #10 was informed of the modern documentation for admini Pro-Stat on 7/18, 7/19 and There was no negative out resident #10.	nissing stration of 17/20/16.
	quarterly MDS (minimometry MDS) (minimometry MDS) (assessmont) (assess	atterns) of the Residents um data set) assessment nent reference date) of ented summary score of 8		The attending physician for #12 was notified that the 7 for "evaluation of new whe cushion" had not been com Physical Therapy completed evaluation on 7/28/16 and recommended a Roho cush wheelchair. This was order resident and place in wheel received.	/8/16 order eelchair apleted. d the ion to ed for

A review of the Residents eMAR (electronic

received.

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STATEME	NT OF OEFICIENCIES I OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		CONSTRUCTION	OMB NO. 0938-03 (X3) OATE SURVEY COMPLETEO
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NAME O	PROVIOER OR SUPPLIER		1	STR	EET AOORESS, CITY, STATE, ZIP COOE	0772072010
ABING	OON HEALTH CARE LL				51 HARMONY HILLS LANE NGDON, VA 24212	
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F 309	medication administration was (licensed practical nual m. However, LPN)	ration record) indicated that administered by LPN urse) #4 on 05/14/16 at 9:00 #3 documented that for the as "awaiting arrival from	F 30	9	Attending physician for Resider also notified that nonpharmaco interventions were not used pri	ological
	A review of the stat b buspirone (buspar) 5 the stat box for admir	mg tablets were available in			administration of ordered Morp 7/15, 7/16, 7/20 and 7/22/16.	
	surveyor contacted the spoke with pharmacis	ximately 2:00 p.m. the see facility pharmacy and st #1. Pharmacist #1 was			Resident #15s order for dialysis been scanned into the system.	has
	asked if buspar could be cut or split in half for administration. Pharmacist #1 verbalized to the surveyor that buspar tablets could be cut or broken in half.			2.	Any resident has the potential taffected by not having medicate devices available as ordered, if nonpharmacological intervention	ion or
, 1	was asked about the e After reviewing the eM the surveyor that she p	cimately 4:55 p.m. LPN #3 evening dose of buspar. IAR LPN #3 verbalized to probably would have not tablet of buspar in the stat		3.	not offered prior to medication administration or if orders are r written for procedures. Licensed nursing staff will be econ medication administration to	not ducated
5	On 07/28/16 at approx surveyor interviewed L MAR LPN #4 stated b	imately 8:55 a.m. the PN #4. After reviewing the suspar was available in the			the facility's policy and procedu obtaining medication from the pharmacy in a timely manner, u	j

approximately 3:15 p.m.

needed.

stat box and she would have obtained the

medication from the stat box for administration

The administrative staff were notified of the above in a meeting with the survey team on 07/28/16 at

and would have broken or cut the pill in half if

No further information regarding this issue was

emergency stat box, facility's process

scanning of orders into system for all

for ensuring communication with

therapy regarding MD orders and

procedures.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/10/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED С 495409 B. WING NAME OF PROVIDER OR SUPPLIER 07/28/2016 STREET ADDRESS, CITY, STATE, ZIP COOF 15051 HARMONY HILLS LANE ABINGDON HEALTH CARE LLC ABINGDON, VA 24212 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE OEFICIENCY) F 309 Continued From page 24 F 309 provided to the survey team prior to the exit conference. 2. For Resident #10, the facility staff failed to administer the nutritional supplement Pro-stat as 4. The Director of Nursing and/or designee ordered by the physician. will audit new orders and or Resident #10 was admitted to the facility admissions/re-admissions orders 01/01/15. Diagnoses included, but were not and the 24 hour clinical report to ensure limited to, dementia, anemia, hypertension, medication availability and to ensure enlarged prostate, restless leg syndrome, and non-pharmacological interventions are anxiety. documented prior to administering pain Section C (cognitive patterns) of the Residents medications daily (M-F) x4 weeks, then quarterly MDS assessment with an ARD of weekly x8 weeks. Any discrepancies 06/14/16 had a summary score of 7 out of a will be addressed promptly and findings possible 15 points. will be reported to Quality Assurance The Residents clinical record included orders for committee for review and further Pro-Stat Liquid Give 30 cc by mouth three times a analysis of findings. day for Prophylaxis. The order date was 5. Correction date September 12, 2016 documented as 07/18/16 The nursing staff had documented in the clinical record on 07/19 and 07/20/16 "...Medication unavailable, awaiting delivery." The eMAR was marked to indicate the Pro-stat was not administered on 07/18, 07/19, and for 9:00 a.m. and 1:00 p.m. on 07/20. The nursing had documented that the Pro-stat was

administered at 5:00 p.m. on 07/20/16.

Per the facility staff the Pro-stat is not provided by the pharmacy. When asked why the physician had ordered the Pro-stat for Resident #10 the unit manager provided the surveyor with a copy of a lab test indicating the Residents protein level was low at 5.5 the reference range was documented

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	ERS FOR MEDICARI	E & MEDICAID SERVICES		(FORM APPROVI
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07/28/2016
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F 309	Continued From pag as 6.4-8.3.	ue 25	F 30	9	
t t t 3	unavailability of the manavailability of the manavailability of the manavailability of the manavailable at approximation provided to the survey conference. 3a. The facility staff fatherapy department of the physician Resident #12 was really 16/16 with the follow	n regarding this issue was y team prior to the exit illed to notify the physical f an evaluation ordered by	·	Please refer to page 23	3.
e d re (/ B 7 w wi	nd-stage kidney diserysphagia, sleep apne esident was coded on Assessment Protocol IMS (Brief Interview foout of a possible scoras also coded as requ	ase, diabetes, depression, a and gastrostomy. The the MDS with an ARD Date) of 6/23/16 had a per Mental Status) score of the of 15. Resident #12 piring extensive assistance dressing and personal			
by su an the (wi loc	the surveyor on 7/27, rveyor that on 7/8/16 order that stated the grapy) to eval (evaluat heelchair) cushion. "	The surveyor could not not of the PT evaluation in			
Uni	t Manager #1 was no	tified of the above			

documented findings. The surveyor requested to

DEPARTMENT OF HEALTH CENTERS FOR MEDICARI	HAND HUMAN SERVICES E & MEDICAID SERVICES		<u>,</u>	PRINTED: 08/10/20 FORM APPROVE
STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SIRVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER ABINGDON HEALTH CARE LL	c		STREET AODRESS. CITY, STATE, ZIP CODE. 15051 HARMONY HILLS LANE ABINGDON, VA 24212	07/28/2016
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that department. The surveyor notified nursing, assistant dire and clinical services a documented findings. On 7/28/16 at 1:45 pm director came into the to the surveyor concer surveyor notified the p the above documented therapy (PT) director a morning to evaluate the have ordered her a Rowner in 2 days. The softhe evaluation that he #12 this morning. The director what the procest that the nurses had recommend the pT director stated, the order and bring it to happened this time.	the administrator, director of ector, would care specialist specialist of the above on 7/27/16 at 3:45 pm. The physical therapy conference room to speak rning Resident #12. The hysical therapy director of difindings. The physical tated, "I just the order this e resident for this. We ho cushion and it will be surveyor requested a copy ad been done on Resident	F 309	Please refer to page 2	3.
surveyor prior to the exit 3b. The facility staff failed non-pharmacological into administration of a pain refuse.	conference on 7/28/16. d to use erventions prior to the			

Resident #12 was readmitted to the facility on

3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure, end-stage kidney disease, diabetes, depression,

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/10/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) OATE SURVEY IOENTIFICATION NUMBER: A BUILOING COMPLETEO 495409 B WING 07/28/2016 NAME OF PROVIDER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 15051 HARMONY HILLS LANE ABINGDON HEALTH CARE LLC ABINGDON, VA 24212 SUMMARY STATEMENT OF OFFICIENCIES (X4) (O IO PREFIX PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEOED BY FULL PREFIX [X5] EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION! COMPLETION DATE TAG TAG CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY) F 309 Continued From page 27 F 309 resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene. The clinical record of Resident #12 was reviewed by the surveyor on 7/27/16. The physician had ordered "Morphine Sulfate (Concentrate) Solution 20 mg/ml (milligram/milliliter) Give 0.25 Please refer to page 23. ml sublingually (under the tongue) every 4 hours as needed for pain/air hunger." The surveyor noted that Morphine, which is a pain medication, was administrated to Resident #12 on the following dates and times: 7/22/16 at 9:13 pm, 7/20/16 at 10:15 pm, 7/16/16 at 3:14 pm and 7/15/16 at 5:17 pm. There was no documentation noted that non-pharmacological interventions were used prior to the administration of this pain medication for these dates and times. Unit Manager #1 was notified by the surveyor on 7/27/16 at 5:45 pm of the above documented findings. Unit Manager #1 stated to the surveyor that she would have to look into this and get back with the surveyor concerning this matter. On 7/28/16 at 1 pm, the Unit Manager stated, " We looked at the chart and you are right. There were no interventions used before the staff gave the resident the Morphine. "

on 7/28/16 at 3:15 pm.

The administrator, director of nursing, assistant director of nursing and clinical services specialist were notified of the above documented findings

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Re on (na	surveyor prior to the at 4. The facility staff facare and treatment we resident and failed to with the dialysis center #15. The surveyor reviewer record on 7/27/16 and was admitted to the face admitted 12/15/15 wout not limited to end stependence on renal of the surveyor reviewer record on 7/27/16 and was admitted 12/15/15 wout not limited to end stependence on renal of the surveyor reviewer represents the surveyor reviewer record on 7/27/16 and was admitted to the face admitted to end stependence on renal of the surveyor reviewer that the seases, and unsurveyor the seases of the resident we ental status (BIMS) as resident #15's current of the dinitiated 6/10/15 for the face of the reventions/Tasks readill as ordered and coonter as indicated."	n was provided to the exit conference on 7/28/16. illed to ensure the necessary as provided to a dialysis ensure coordination of care of was provided for Resident december was provided for Re	F 30	Please refer to pag	ge 23.

documents for dialysis.

The surveyor reviewed the electronic clinical record and was unable to locate any scanned

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F 309 Continued From pag	e 29	F 30	99	
#2 on 7/28/16 at 8:35 the facility had comm the dialysis center an provided the surveyor Resident #15. L.P.N. notebook from Reside The July 2016 Dialysis	wed licensed practical nurse a.m. L.P.N. #2 was asked if unication sheets between d the facility. L.P.N. #2 with a dialysis notebook for #2 obtained the dialysis ent #15's dialysis duffel bag.			
was reviewed. Entries date, weight (pre) weig condition, changes in a nutrition % taken, and entries on the dialysis entirely. L.P.N. #2 stat a communication shee	s on the form included: ght (post), labs, changes in medications, diet to center, signature. Of the eight form, none were completed ted the facility doesn't send t to the dialysis center went to dialysis. "We are led the surveyor the		Please refer to pag	e 23.
There were no dialysis used to share the flow of facility and the dialysis of	of information between the			
9:25 a.m. R.N. #1 state	R.N. #1 provided ed at the dialysis center f1 stated the dialysis			
The surveyor requested dialysis from the adminis	the facility contract for trator on 7/28/16.			
The contract titled "SNF of Services Agreement" read	Outpatient Dialysis d in part "A. Obligations			

STATEMENT O DEFICIENCIES AND PLAN OF CORRECTION ASSUMBLY A95409 A95409 A95409 A95409 A95409 ASTREET ADDRESS. CITY. STATE. ZIP CODE 15051 HARMONY HILLS LANE ABINGDON HEALTH CARE LLC ABINGDON HEALTH CARE LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG FOUNDERS OF RESULT OR YOU CAN THE APPROPRIATE FOR CONSTRUCTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG FOR CONTINUED FROM PROPRIATE FOR CONSTRUCTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG FOR CONSTRUCTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE FOR ONLY STATEMENT OF THE APPROPRIATE THE STATEMENT OF THE APPROPRIATE	DEPARTMENT OF HEALTH	IEALTH AND A AAN SERVICES		(PRINTED: 08/10/2016
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ABINGDON HEALTH CARE LLC 1991 HARMONY VILLS LANE ABINGDON, VA 24212 1992 1993 1994 1995 1995 1995 1995			B. WING_		· · ·
ABINGDON HEALTH CARE LLC (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 30 of Nursing Facility and/or Owner 2. Interchange of Information. The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD (end stage renal disease) Residents, including a Registered Nurse as a contact person at the Nursing Facility whose responsibilities include oversight of provision of Services to the ESRD Dialysis Unit and/or Company D. To provide to the Nursing Facility information on all aspects of the management of the ESRD Residents care related to the provision of Services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infection, and care of dialysis site." The surveyor informed the administrator, the director of nursing, and the assistant director of nursing, and the assistant director of nursing of the lack of coordination of dialysis care for Resident #15 with the contracting dialysis center on 7/28/16 at 10:40 a.m. No further information was provided prior to the exit conference on 7/28/16.	NAME OF PROVIDER OR SUPPLIER	PPLIER		STREET ADDRESS CITY STATE 710 0005	07/28/2016
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 30 of Nursing Facility and/or Owner 2. Interchange of Information. The Nursing Facility shall provide for the interchange of information. In Section 1 the ESRD Residents. B. Obligations of the ESRD Isality whose responsibilities include oversight of provision of Services to the ESRD Residents. B. Obligations of the ESRD Dialysis Unit and/or Company D. To provide to the Nursing Facility information on all aspects of the management of the ESRD Residents of the ESRD Residents. B. Obligations of the ESRD Isality information on all aspects of the management of medical and non-medical emergencies, including, but not limited to, bleeding, infection, and care of dialysis site." The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the lack of coordination of dialysis care for Resident #15 with the contracting dialysis center on 7/28/16 at 10:40 a.m. No further information was provided prior to the exit conference on 7/28/16.	ABINGDON HEALTH CARE LLC	ARE LLC		15051 HARMONY HILLS LANE	
of Nursing Facility and/or Owner 2. Interchange of Information. The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD (end stage renal disease) Residents, including a Registered Nurse as a contact person at the Nursing Facility whose responsibilities include oversight of provision of Services to the ESRD Residents. B. Obligations of the ESRD Dialysis Unit and/or Company D. To provide to the Nursing Facility information on all aspects of the management of the ESRD Resident's care related to the provision of Services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infection, and care of dialysis site." The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the lack of coordination of dialysis care for Resident #15 with the contracting dialysis center on 7/28/16 at 10:40 a.m. No further information was provided prior to the exit conference on 7/28/16.	PREFIX (EACH DEFICIENCY M	ICIENCY MUST BE PRECEDED BY EUL	ID PREFIX	PROVIDER'S PLAN OF CORRECTII (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D.RE COMPLETION
F 329 SS=D UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	of Nursing Facility and of Information. The N for the interchange of necessary for the care renal disease) Resider Nurse as a contact per whose responsibilities provision of Services to Obligations of the ESR Company D. To provide information on all aspect the ESRD Resident's conformation on all aspect the ESRD Resident's conformation on the ESRD Resident's conformed including, but not limited and care of dialysis site. The surveyor informed the director of nursing, and the nursing of the lack of confor Resident #15 with the center on 7/28/16 at 10:4 No further information was exit conference on 7/28/16 at 10:4 No further information was exit conference on 7/28/16 at 10:4 Each resident's drug region unnecessary drugs. An undrug when used in excess duplicate therapy); or for exithout adequate monitori indications for its use; or in adverse consequences whishould be reduced or discontinuations.	cility and/or Owner 2. Interchange The Nursing Facility shall provide ange of information useful or the care of the ESRD (end stage Residents, including a Registered ntact person at the Nursing Facility sibilities include oversight of rvices to the ESRD Residents. B. he ESRD Dialysis Unit and/or o provide to the Nursing Facility all aspects of the management of dent's care related to the provision luding directions on management non-medical emergencies, of limited to, bleeding, infection, rvsis site." formed the administrator, the fing, and the assistant director of ck of coordination of dialysis care with the contracting dialysis at 10:40 a.m. ation was provided prior to the on 7/28/16. REGIMEN IS FREE FROM DRUGS rug regimen must be free from lis. An unnecessary drug is any of excessive dose (including it or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose or discontinued or any			23.

DEPARTMENT OF HEALTH AND LUMAN SERVICES PRINTED: 08/10/2016 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 495409 B. WNG 07/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON HEALTH CARE LLC ABINGDON, VA 24212 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** IEACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 329 Continued From page 31 F 329 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug F 329 Drug Regimen is Free from therapy is necessary to treat a specific condition Unnecessary Drugs as diagnosed and documented in the clinical record; and residents who use antipsychotic 1. The parameters needed for resident drugs receive gradual dose reductions, and #10s administration of metoprolol have behavioral interventions, unless clinically contraindicated, in an effort to discontinue these been placed on the medication drugs. administration record (MAR). 2. Any resident with medications that require parameters has the potential to be affected. Residents with parameters for medication administration will have This REQUIREMENT is not met as evidenced their records audited to ensure that required parameters for administration Based on staff interview and clinical record are on the MAR with the medication. review, the facility staff failed to follow physician ordered parameters prior to administering a DON will complete education for hypertensive medication for 1 of 27 Residents, licensed staff on having parameters on Resident #10. the MAR. 4. The D.O.N or designee will conduct The findings included. audits on physician orders with

The facility staff failed to follow the physician ordered parameters regarding a blood pressure medication.

Resident #10 was admitted to the facility 01/01/15. Diagnoses included, but were not limited to, dementia, anemia, hypertension, enlarged prostate, restless leg syndrome, and anxiety.

Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD of 06/14/16 had a summary score of 7 out of a

parameters X3 months to ensure

require the parameters. Any discrepancies will be addressed

5. Correction date September 12,

parameters are located on MARS that

promptly and findings will be reported

review and further analysis of findings.

to Quality Assurance committee for

CENTERS FOR MEDICARE	I AND I ^L . JAN SERVICES E&MEDICAID SERVICES		(PRINTED: 08/10/20 FORM APPROV
TATEMENT OF OEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NIJMBER	(X2) MUL A BUILDI	TIPLE CONSTRUCTION NG	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
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included the active di The Residents clinica	ection I (active diagnoses) agnosis of hypertension. I record included physician	F 329)	
orders for "Metoprolo 1 tablet by mouth at b Hold for Systolic BP (I than) 100 or diastolic	Tartrate Tablet 25 MG Give dedtime for Hypertension plood pressure) < (less BP <60 or Heart Rate <60. pector) if held three times or			
medication administrate this medication had be night at 2100 (9:00 p.n However, the surveyor	n.) for the month of July. was unable to locate ate the parameters set by		Please refer to page 32	
On 07/26/16 at approxisurveyor and the unit magnetical recording able to provide the had been obtained on-07/04 at 11:02 a.m. 07/05 at 10:29 a.m. 07/06 at 9:45 a.m. 07/07 at 14:50 (2:50 p.m.)	nanager reviewed the d. The unit manager was surveyor with BPs that			

No heart rates were provided.

The administrative staff were notified of the

Event IO: SOHX11

Facility IO: VA0406

If continuation sheet Page 33 of 56

AUG 24 2016 VDH/OLC

PRINTED: 08/10/2016 DEPARTMENT OF HEALTH AND A MAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING C 495409 B WING 07/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON HEALTH CARE LLC ABINGDON, VA 24212 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 329 Continued From page 33 F 329 Please refer to page 32 missing physician ordered parameters during a meeting with the survey team on 07/28/16 at approximately 3:15 p.m. No further vital signs were provided to the surveyor prior to the exit conference. F 332 483.25(m)(1) FREE OF MEDICATION ERROR F 332 SS=D RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. F 332 Medication Error Rate 1. A medication error report has been This REQUIREMENT is not met as evidenced completed for the administration of by: resident #15's eye drops. The physician Based on observation, staff interview, facility was notified of error. document review and clinical record review, the A medication error report has been facility staff failed to ensure a medication error completed for Resident #26's Cymbalta rate less than 5 %. There were 2 medication errors out of 27 opportunities for a medication that was crushed. The physician was error rate of 7.4% that affected 2 of 27 residents notified of error. (Resident #15 and Resident #26). 2. Any resident who receives medications has the potential to be affected by a The finding included: 1. The facility staff failed to administer Resident medication error. #15's eye drops by the manufacturer's package 3. Licensed nursing staff will be educated insert. The facility staff failed to wait 3 minutes on the proper method of administering between each eye drop administered into medications to include eye drops and

Resident #15's eyes.

The surveyor observed a medication pass and pour on 7/26/16 at 4:40 p.m. with licensed practical nurse #1. L.P.N. #1 prepared two medications for Resident #15-Renvela and Artificial Tears Solution 1.4 % (Polyvinyl Alcohol). L.P.N. #1 placed the Renvela in a medication cup

applesauce. L.P.N. #1 then donned gloves and

and administered the medication with

medications that cannot be crushed.

	CENTERS	FOR MEDICARI	& MEDICAID SERVICES				OMB NO. 0938-03
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ı	NAME OF PRO	VIDER OR SUPPLIER		1	STF	EET ADDRESS, CITY, STATE, ZIP CODE	1 01/20/2016
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	pla eye The pro L.P Res brie L.P eye The adn date Teal drop DRN LAC The pack nurs The "Poli Effect 8/7/2 State regis surve pack #1 no receiv adminute time for	e followed by a see a same eye medicedure was obsee. N. #1 offered Resident #15 dabbed fily. I.N. #1 failed to was drop administration is required files between drops or each eye drop. If an analon is required files between drops or each eye drop.	the Artificial Tears in the left cond drop in the left eye. Station administration rived with the right eye. Stident #15 a tissue. If the corner of both eyes with 3-5 minutes between each on of the Artificial Tears. It is medications signed physician order hysician order read "Artificial Polyvinyl Alcohol) Instill 2 pur times a day related to the manufacturer's cations from registered to the manufacturer's cations from registered to the manufacturer's cations from registered to the facility policy titled nic Drop Administration 09, Revised Date: 12. 8/1/2010, 10/1/2011, Ill regions" by the corporate 7/27/16 at 11:00 a.m. The did the manufacturer's a specifications from R.N. 2. The surveyor did not sert with specifications for cal Tears from the facility dure Note: If more than nedication is required for additional eye drop or administration, wait 3-5 to allow adequate contact in was obtained from the	F 33	4.	DON and/or designee will cormedication pass observations 4 weeks and then 1 weekly X monitor for correct medication administration. Any discrepabe addressed promptly and fit be reported to Quality Assura committee for review and furtionallysis of findings. Correction date September 12	s weekly X 8 weeks to on ancies will ndings will nce ther
	time fo The fo	or each eye drop.' Illowing informatio	·				

medication administration: "Eye Contact: The

Event ID: SOHX11

Facility ID: VA0406

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DEPARTMENT OF HEALTH AND MAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	PRINTED: 08/10/2016 FORM APPROVED
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eye drop, but not the dropper, must make full contact with the conjunctival sac and then be washed over the eye when the resident closes the eyelid; and Sufficient Contact Time: The eye drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately 3 to 5 minutes. (It should be encouraged that when the procedures are possible, systemic effects of eye medications can be reduced by pressing the tear duct for one minute after eye drop administration or by gentle eye closing for approximately three minutes after the administration.)" The surveyor discussed the medication pass observation with L.P.N. #1 on 7/27/16 at 3:40 p.m. L.P.N. #1 stated she didn't know that there was a 3-5 wait time between drops for artifical tears. She stated she thought that was just for medicated eye drops. The surveyor informed the administrative staff of the above finding on 7/27/16 at 3:50 p.m. and requested the facility policy on medication administration. No further information was provided prior to the exit conference on 7/28/16. Resident #15's clinical record on 7/27/16 and 7/28/16. Resident #15 was admitted to the facility 2/18/13 and readmitted 12/15/15 with diagnoses that included but not limited to end stage renal disease, dependence on renal dialysis, schizoaffective disorder, bjoolar type, major depressive disorder, hypertensive chronic kidney disease, dependence on renal dialysis, schizoaffective disorder, bypothyroldism, gastroesophageal	page 34

DEPAR	TMENT OF HEALTH	AND JMAN SERVICES		(PRINTED: 08/10/2016
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i i i	Resident #15's signification minimum data set (Massessment reference assessed the residen mental status (BIMS)	nspecified psychosis. icant change in assessment DS) assessment with an e date (ARD) of 12/22/15 t with a brief interview for	F 33	2 Please refer to page	. 34
T p p m w C C po the L.F pla and with	furing a medication particle out on 7/27/16 at 8:00 ractical nurse #2. L.F. nedications for Reside rere ASA (aspirin), Olaymbalta, Lasix, Lopre hloride. L.P.N. #2 was plassium tablet in a gle potassium would diaced the ASA, Lisinor pressor in a medication mbalta 30 mg (millignered the capsule and example capsule (beads) in 2.N. #2 then placed a stic sleeve and crush ced the crushed med diadministered them to the dissolved potasses surveyor asked if the	d a medication pass and a.m. with licensed P.N. #2 prepared six (6) ent #26. The medications anzapine, Lisinopril, essor, and Potassium as observed to place the lass of water. She stated solve. L.P.N. #2 then pril, Olanzapine, Lasix and ion cup. She removed rams) from the package, diplaced the contents of the medication cup. If the medications in a need them. L.P.N. #2 lications in applesauce to Resident #26 along sium.			
Cru to ti revi	ish list. L.P.N. #2 pro he surveyor. The sur iewed the list. Cymba	vided a Do Not Crush list vevor and L.P.N. #2			

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crushed. L.P.N. #2 asked "Is it ok to open the

capsule and just give the beads?"

The surveyor reconciled Resident #26's

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DEPARTMENT OF HEALTH AND MAN SERVICES PRINTED: 08/10/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 495409 B. WING NAME OF PROVIDER OR SUPPLIER 07/28/2016 STREET ADDRESS, CITY, STATE, ZIP CODE ABINGDON HEALTH CARE LLC 15051 HARMONY HILLS LANE ABINGDON, VA 24212 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** TAG (EACH CORRECTIVE ACTION SHOULD BE (X51 COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 332 Continued From page 37 F 332 medications administered with the signed physician orders dated 7/11/16. Resident #26 did have physician orders that read "Duloxetine HCL Capsule Delayed Release Particles 30 mg Give 1 capsule by mouth one time a day related to ANXIETY STATE, UNSPECIFIED (300.00)." The surveyor requested the facility contracting pharmacy phone number and placed a call to the contracting pharmacist on 7/27/16 at 9:12 a.m. Please refer to page 34 The surveyor interviewed the contracting pharmacist (other #1) concerning the crushing of Cymbalta. The pharmacist stated he would do his research and inform the surveyor of the results. The information provided from the contracting pharmacist was reviewed 7/27/16. The information titled "Duloxetine HCL (hydrochloride) Alternative Methods of Transmission" read in part "Duloxetine delayed-release capsules should be swallowed whole and should not be chewed or crushed, nor should the capsule be opened and its contents sprinkled on food or mixed with liquids. Based on the findings from that study, the authors concluded that the enteric coating of the duloxetine pellets was not negatively affected after being mixed with applesauce and apple juice (each with a pH of approximately 3.5) provided that the pellets were not crushed, chewed, or otherwise broken (Wells, 2008)." A return call to the contracting pharmacist on

when crushed

7/27/16 at 3:09 p.m. was made. The contracting pharmacist stated Cymbalta should not be crushed because it alters the contents of the drug

		100			z**		
		I AND HUMAN SERVICES 8 MEDICAID SERVICES			(FOR	D: 08/10/201 MAPPROVEI
STATEMEN	IT OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) OA	O. 0938-039 ATE SURVEY OMPLETED
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F 332	Continued From pag	ge 38	F 30	32	-		
	the above issue on	7/27/16 at 3:50 p.m.		_			
	No further information exit conference on 7	on was provided prior to the 7/28/16.					
	with diagnoses that in dementia without be failure, chronic kidner psychotic disorder. A (MDS) assessment varieference date (ARD	Annual minimum data set with an assessment of 7/18/16 assessed brief interview for mental CURE,	F 37	F 3/1			
	considered satisfactor authorities; and (2) Store, prepare, disunder sanitary condit	is not met as evidenced			Hot food items below 135 degree removed from to and returned to be reheated. No allowed the plathermometer to items. All residents had to be affected ware not held at	rees were the steam to the kitcher loted the se estic part of o touch food eve the pote when food it	able n to rver d
		ns, staff interviews, and a ew, the facility's staff failed		2	temperature.	محمد الشياط	

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The findings include:

manner.

to store, and serve food in a safe and sanitary

The tray line temperature observation was

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Facility IO: VA0406

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3. The consulting RD will inservice

higher & appropriate use of thermometers. The CDM will in-

service dietary staff will be in-

dietary staff regarding holding

temperatures at 135 degrees or

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2016 FORM APPROVED OMB NO. 0938-0391

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F 371	conducted on 3 unit 5:00pm. The survey the tray line temperatemperatures on the at 135 degrees or grunee meat was 130 vegetables was 134 fries were 126 degrees server what she was respond for a while a	ge 39 s on 7/26/16 starting at or asked the server to check atures on the 1st unit. The tray line were not maintained reater. On the 1st unit the degrees the pureed degrees. When the French res the surveyor asked the going to do, she did not and then said "I will need to chen to be reheated." She	F 3 7	serviced regarding temperatures, for and serving methor cross contaminati 4. The cooking temperature checked by the cooking temperature checked by the cooking temps to ditems being the serving units a on daily logs for all	od preparation, ods to prevent on. eratures & ures will be ok prior to transported to and recorded

On the 2nd unit the surveyor asked the server to take the tray line temperatures. While taking the temperature of the hamburgers she touched the patties with the plastic part of the thermometer. The surveyor also noticed the hamburger buns still in the plastic bag lying partly on top of the French fries.

then began to take the food from the steam table.

food thermometer to touch the French fries twice

The server also allowed the plastic part of the

while taking the temperature.

The temperature of the French fries was 122 degrees, the puree vegetables were 128.3 degrees, the puree meat was 125.8 and the cooked apple sauce was 131. When the surveyor asked the server what she was going to do about the food she said "I would reheat it, but I have not been educated on what to do."

On the third unit the server also allowed the plastic part of the thermometer to touch the mashed potatoes. The puree vegetables were 123 degrees, the gravy 128 degrees, the mechanical meat 125.8 degrees, the green beans 116 degrees and the applesauce 109 degrees. When asked what she should do about the low temperatures the server said "I would serve it."

- on daily logs for all 3 meals. This will be an ongoing process. The CDM or Supervisor will check temperatures 5 meals per week x 4 weeks, 3 meals per week x 4 weeks, followed by 2 meals per week x 4 weeks. CDM / Supervisor / RD will conduct sanitation rounds 2 times per week for 4 weeks and then weekly X 8. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.
- Correction date September 12, 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2016 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495409	B. WING		C 07/29/2046
		TEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212 PROVIDER'S PLAN OF CORRECTION	07/28/2016
PREFIX TAG		'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		D BE COMPLETION
F 387 SS=D	A meeting was held with the dietary manager and the dietician on the morning of 7/27/16 at 10:00 am. During the meeting the tray line temperatures and the aforementioned concerns was discussed. At the end of the day meeting on 7/27/16 the kitchen issues were discussed with the administrative staff. Prior to exit on 7/28/16 the dietician informed the surveyor of in-service education with the dietary staff related to the aforementioned concerns. 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.				
i i i t t	This REQUIREMENT by: Based on staff intervi review, the facility staff residents (Resident #8 ohysician at least ever review of 10 days. Re rephysician for 90 da The findings included: Resident #8 was not stays.	y 60 days with a grace sident #8 was not seen by		Resident # 8 has been seen by MD. Any resident has the potential to be affected if timely physician visits an obtained. Medical Records will complete an audit of physician visit dates to determine if any other residents are affected. The D.O.N. will educate Medical Records Secretary on scheduling physician visits at least once every days for the first 90 days after admission, and at least once every days thereafter.	e re not

CENT	ERS FOR MEDICAR	E & MEDICAID SERVICES		C	FORM APPROV 0MB NO. 0938-03
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F 387	Continued From page	ge 41	F 38	37	
	to Ihe facility 10/25/included but not limi hemiparesis following affecting unspecified	6. Resident #8 was admitted 13 with diagnoses that ited to hemiplegia and ng cerebrovascular disease d side, pseudobulbar effect,		The D.O.N. and Medical Records Secretary will review physician visit schedules weekly for accuracy for 3	
vascular dementia without behavioral disturbance, chronic obstructive pulmonary disease, Type 2 diabetes mellitus, dysphagia, insomnia, major depressive disorder, hypertension, blepharitis left lower eyelid, nuclear cataract, bilateral, migraine without aura, Vitamin B12 deficiency, Vitamin D deficiency, and anxiety.			months. Any discrepancies will be addressed promptly and findings wi reported to Quality Assurance committee for review and further analysis of findings.	II be	
;	assessed the residen	essessment with an e date (ARD) of 6/6/16	5.	Correction date September 12, 2016	5
/ s 1 u	August 2015 through seen by the physician 2/16/15 and then on mable to locate a phy	od the physician visits from present. Resident #8 was and a note written on 3/15/16. The surveyor was esician visit between these petween physician visits was			
T tł	he surveyor informed ne above finding on 7	the administrative staff of /27/16 at 3:50 p.m.			
Ol		rmed by the administrator . that a physician visit note			
N	o further information v	was provided prior to the			

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exit conference on 7/28/16. F 425 483.60(a),(b) PHARMACEUTICAL SVC -

SS=D ACCURATE PROCEDURES, RPH

Event IO SOHX 11

Facility IO: VA0406

F 425

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DEPARTMENT OF HEALTH AND A JAN SERVICES PRINTED: 08/10/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING COMPLETED С 495409 B WING 07/28/2016 NAME OF PROVIOER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP COOE ABINGDON HEALTH CARE LLC 15051 HARMONY HILLS LANE ABINGDON, VA 24212 SUMMARY STATEMENT OF OFFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDEO BY FULL 12X1 PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 425 Continued From page 42 F 425 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in F 425 Pharmaceutical Svc. Accurate §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State **Procedures** law permits, but only under the general supervision of a licensed nurse. 1. The attending physician for resident #12 was informed of the missing A facility must provide pharmaceutical services (including procedures that assure the accurate documentation for administration of acquiring, receiving, dispensing, and Prilosec packet on 7/24, 7/25 and administering of all drugs and biologicals) to meet 7/26/16. There was no negative the needs of each resident. outcome to resident #10. The attending physician for resident The facility must employ or obtain the services of a licensed pharmacist who provides consultation #13 was informed of the missing on all aspects of the provision of pharmacy documentation for administration of services in the facility. Prilosec on 7/10/16. There was no negative outcome to resident #13. MARs were reviewed, pharmacy called This REQUIREMENT is not met as evidenced and medications received for residents # 12 and #13. Based on staff interview and clinical record

Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for 2 of 27 residents. (Resident #12 and #13)

The findings included:

1. The facility staff failed to ensure that Prilosec was available for administration to Resident #12.

Resident #12 was readmitted to the facility on 3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure,

- Any resident has the potential to be affected if medication is not available as ordered.
- Licensed nursing staff will be educated on medication administration to include the facility's policy and procedure for obtaining medication from the pharmacy in a timely manner and use of emergency stat box

DEPARTMENT OF HEALTH AND(MAN SERVICES PRINTED: 08/10/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 495409 B. WING NAME OF PROVIDER OR SUPPLIER 07/28/2016 STREET ADDRESS, CITY, STATE, ZIP CODE ABINGDON HEALTH CARE LLC 15051 HARMONY HILLS LANE ABINGDON, VA 24212 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDEO BY FULL ID PROVIDER'S PLAN OF CORRECTION PREFIX IX5r **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY) F 425 Continued From page 43 F 425 end-stage kidney disease, diabetes, depression, dysphagia, sleep apnea and gastrostomy. The resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 4. The Director of Nursing and/or designee 7 out of a possible score of 15. Resident #12 will audit the 24 hour clinical report to was also coded as requiring extensive assistance ensure medication availability daily (Mwith 1 staff member for dressing and personal F) x4 weeks, then weekly x8 weeks. hygiene. Any discrepancies will be addressed The surveyor conducted a review Resident #12 ' promptly and findings will be reported s clinical record on 7/27/16. The surveyor noted to Quality Assurance committee for an order "Prilosec Packet 10 mg (milligram) review and further analysis of findings. ...Give 1 packet via (by) peg tube in the morning 5. Correction date September 12, 2016 It was noted on the Resident 's MAR (Medication Administration Record) on 7/24/16 at 6 am, 7/25/16 at 6 am and 7/26/16 at 6 am that Prilosec was not given. In the nurses ' notes for the above documented dates and times, the surveyor noted documentation that stated " not here from pharmacy " or " not in from pharmacy. Unit Manager #1 was notified of the above documented findings on 7/27/16 at 5:45 pm by the surveyor. On 7/28/16 at 1 pm, Unit Manager #1 stated, " The staff had run out of the Prilosec packets and

were waiting to get it from pharmacy.

No further information was provided to the surveyor prior to the exit conference on 7/28/16.

findings on 7/28/16 at 3:15 pm.

The administrator, director of nursing, assistant director of nursing and the clinical services specialist were notified of the above documented

CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND (//AN SERVICES & MEDICAID SERVICES		\	PRINTED: 08/10/2016 FORM APPROVED OMB NO. 0938-0391
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NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	07/28/2016
ABINGDO	ON HEALTH CARE LL			15051 HARMONY HILLS LANE ABINGDON, VA 24212	
(X4) ID PREFIX TAG	(EACH DEFICIENCY:	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OBE COMPLETION
F 425	Continued From pag	e 44	F 42	5	
	 The facility staff was available for adn 	failed to ensure that Prilosec ninistration to Resident #13.			
F fa g c w 7/ lo se re m hy	8/30/16 with the follow mited to blood clot, the parkinson is Disease ailure, intracranial he astrostomy and chrooded, on the MDS (a with an ARD (Assessment #13 was everely impaired to missident requires exteriore staff members for giene and was totally withing.	admitted to the facility on ving diagnoses of, but not hyroid disorder, dementia, , seizures, respiratory morrhage, tracheostomy, nic pain. The resident was n assessment protocol) nent Reference Date) of rt and long term memory as also coded as being take daily decisions. The asive assistance with 2 or r dressing and personal y dependent on staff for		Please refer to page 4	3
by no su sta no	the surveyor on 7/27 tes for 7/10/16 at 2:2 rveyor noted there wated, " awaiting from	esident #13 was reviewed 1/2016. In the nurses 1/2016. In the nurses 1/2016 pm and at 10:03 pm, the as documentation that pharmacy. 1/20 There was a medication that staff was to obtain.			
dod	it Manager #1 was no cumented findings on surveyor.	otified of the above 7/27/16 at 5:45 pm by			
Mar beir abo stat	nager #1 if she knew ng referred to in the n ve days for Resident	surveyor asked Unit what medication was urses 'notes on the #13. Unit Manager #1 sec that the staff was nacy."			

FORM CMS-2567(02-99) Previous Versions Obsolele

Eveni ID: SOHX11

Facility ID: VA0406

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AUG 24 2016 VDH/OLC

CENTERS FOR MEDICAR	THANE IMAN SERVICES RE & MEDICAID SERVICES		(PRINTED: 08/10/20 FORM APPROV
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		PLE CONSTRUCTION G	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
·	495409	B WING	— ———	С
NAME OF PROVIDER OR SUPPLIER	?		STREET ADDRESS OF	07/28/2016
ABINGDON HEALTH CARE L			STREET ADDRESS. CITY, STATE. ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212	
TREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
F 425 Continued From pa	ge 45	F 425		· · · · · · · · · · · · · · · · · · ·
The administrator, of director of nursing a	director of nursing, assistant and the clinical services ied of the above documented	F 475	Please refer to page 4	3
surveyor prior to the 441 483.65 INFECTION S=D SPREAD, LINENS		F 441		
safe, sanitary and co	blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on.			
Program under which	olish an Infection Control it -	F 441 In	fection Control	
(1) Investigates, controlin the facility;(2) Decides what procishould be applied to a	ols, and prevents infections edures, such as isolation, n individual resident; and of incidents and corrective	\ 2 \ h	Handwashing education was comple with nurse #3 in regards to Residen 25 and #27. Education was comple with nurse #4 on infection control a nandwashing when performing wou	t # ted and
(2) The facility must pro communicable disease	Control Program ent needs isolation to fection, the facility must	2. A a p 3. T s: a	are in regards to Resident # 4. Any resident has the potential to be ffected if handwashing is not erformed. The DON will educate licensed nursication the importance of handwashing infection control when deministering medication or perforn	ng ning

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(3) The facility must require staff to wash their

hand washing is indicated by accepted

hands after each direct resident contact for which

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Facility ID: VA0406

wound care.

If continuation sheel Page 46 of 56

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DEPARTMENT OF HEALTH AND **JMAN SERVICES** PRINTED: 08/10/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495409 B WING NAME OF PROVIDER OR SUPPLIER 07/28/2016 STREET ADDRESS, CITY, STATE, ZIP CODE **ABINGDON HEALTH CARE LLC** 15051 HARMONY HILLS LANE ABINGDON, VA 24212 SUMMARY STATEMENT OF DEFICIENCIES (X4LID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **IX5**1 **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION! TAG COMPLETION DATE TAG DEFICIENCY) F 441 Continued From page 46 F 441 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of DON and/or designee will conduct (3) infection medication pass observations weekly X 4 weeks and then (1) weekly X 8 weeks to monitor for appropriate This REQUIREMENT is not met as evidenced handwashing. DON or designee will by: conduct (2) wound care observation Based on observation, staff interview, facility document review, and clinical record review, the weekly X 4 weeks and then (1) wound facility staff failed to follow infection control care observation weekly X 8 weeks to guidelines for 3 of 27 residents (Resident #25, monitor for appropriate handwashing. Resident #27, and Resident #4). Any discrepancies will be addressed The findings included: promptly and findings will be reported to Quality Assurance committee for 1. The facility staff failed to perform hand review and further analysis of findings. hygiene during a medication pass observation 5. Correction date September 12, 2016 that affected Resident #25 and Resident #27. The surveyor observed a medication pass and pour with licensed practical nurse #3 on 7/26/16 at 4:15 p.m. L.P.N. #3 obtained a blood sugar from Resident #25 and then prepared Resident #25 's evening insulin injection. L.P.N. #3 donned non-sterile gloves and administered the insulin in the left abdomen, discarded both sharps and removed the gloves. L.P.N. #3 did not perform hand hygiene. L.P.N. #3 then began to

set up Resident #27's medications that included

administering them. L.P.N. #3 did not perform hand hygiene between the two residents

three medications and was observed

observed in the medication pass.

TATEMENT ND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		PLE CONSTRUCTION	MB NO. 0938-0 (X3) DATE SURVEY
	!		A BUILDIN	G	COMPLETED
IANE OF I	PROVIDER OR SUPPLIER	495409	B WING_		C 07/28/201 6
				STREET ADDRESS, CITY, STATE, ZIP CODE	
BINGDO	ON HEALTH CARE LL	С	}	15051 HARMONY HILLS LANE	
(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES		ABINGDON, VA 24212	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETIO
F 441	Continued From pag	e 47	F 444		
		Hygiene from registered	F 441		
i	ourse #4 on 7/27/16	at 8:00 a.m.			
7	The facility policy title	ed "Procedure for			
ŀ	landwashing" include	ed a section that read			
,,	When to Wash Hand	ds (at a minimum)." The		Please refer to page 46	
S	ection read in part "E ontact."	Before and after resident		, ,	
7	he facility managem	nent team was made aware			
~	The second of the second				
U	the findings on 7/27	7/16 at 3:50 p.m.			
7	f the findings on 7 /27 he administrative nu	7/16 at 3:50 p.m. rses in the meeting were			
T as	f the findings on 7 /27 he administrative nur sked when hands sh	7/16 at 3:50 p.m. rses in the meeting were ould be washed. The			
T a: co	f the findings on 7 /27 he administrative nur sked when hands sh orporate nurse #2 sta	7/16 at 3:50 p.m. rses in the meeting were ould be washed. The ated between residents.			
Ti as co Ri	f the findings on 7/27 he administrative nur sked when hands sho prporate nurse #2 sta esident #25 was adm	7/16 at 3:50 p.m. rses in the meeting were ould be washed. The ated between residents. nitted to the facility 5/20/16			
T as co R wi re	f the findings on 7/27 he administrative nursked when hands shorporate nurse #2 states admitted the diagnoses that incomprint for the diagnoses that incomprint for the diagnoses that incomprint of t	7/16 at 3:50 p.m. rses in the meeting were ould be washed. The ated between residents. nitted to the facility 5/20/16 cluded pneumonia, chronic onic obstructive pulmonary			
T co R wi re dis	f the findings on 7/27 he administrative nursked when hands shopporate nurse #2 states dent #25 was admith diagnoses that incomprised the control of the con	7/16 at 3:50 p.m. rses in the meeting were ould be washed. The ated between residents. nitted to the facility 5/20/16 cluded pneumonia, chronic onic obstructive pulmonary and Type 2 diabetes mellitus.			
T as co Ri wi re dis Se	the findings on 7/27 he administrative nursked when hands shorporate nurse #2 states dent #25 was admith diagnoses that inceptions of the signification C of the	7/16 at 3:50 p.m. rses in the meeting were ould be washed. The ated between residents. nitted to the facility 5/20/16 cluded pneumonia, chronic onic obstructive pulmonary and Type 2 diabetes mellitus. cant change in			
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T as co	the findings on 7/27 he administrative nursely when hands show the diagnoses that incomply failure, chrosease, dysphagia, and estion C of the signification C of 5/26/16 was reveyor as requested. Sident #27 was admin diagnoses that inclination inflammatory dependent of the confect	7/16 at 3:50 p.m. rses in the meeting were ould be washed. The ated between residents. nitted to the facility 5/20/16 cluded pneumonia, chronic onic obstructive pulmonary nd Type 2 diabetes mellitus. cant change in data set (MDS) rsessment reference date not provided to the itted to the facility 11/21/13 luded but not limited to emyelinating polyneuritis, s, dementia without s, hypertension, and dry MDS assessment with an sessed the resident with a re of 14.			
T as co Ri with red dispersion of the control of th	the findings on 7/27 he administrative nursely when hands show the proporate nurse #2 states ident #25 was admit diagnoses that incomprished the sease, dysphagia, and ection C of the signification C of 5/26/16 was reversely of 5/26/16 was reversely and the content with a signification of the content with the content with the content with the content with the content of the content with the content	7/16 at 3:50 p.m. rses in the meeting were ould be washed. The ated between residents. nitted to the facility 5/20/16 cluded pneumonia, chronic onic obstructive pulmonary nd Type 2 diabetes mellitus. cant change in data set (MDS) sessment reference date not provided to the itted to the facility 11/21/13 luded but not limited to emyelinating polyneuritis, s, dementia without s, hypertension, and dry MDS assessment with an sessed the resident with a le of 14. ras provided prior to the			
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T as cc Riving re is set as (Al suit chromatics as (Al suit chromatics) Re exit chromatics (Al suit chromatics) Re exit cog No exit 2.	the findings on 7/27 he administrative nursely when hands show the proporate nurse #2 states ident #25 was admit diagnoses that incomprished the sease, dysphagia, and ection C of the signification C of 5/26/16 was reversely of 5/26/16 was reversely and the content with a signification of the content with the content with the content with the content with the content of the content with the content	7/16 at 3:50 p.m. rses in the meeting were ould be washed. The ated between residents. nitted to the facility 5/20/16 cluded pneumonia, chronic onic obstructive pulmonary nd Type 2 diabetes mellitus. cant change in data set (MDS) sessment reference date not provided to the itted to the facility 11/21/13 luded but not limited to emyelinating polyneuritis, s, dementia without s, hypertension, and dry MDS assessment with an sessed the resident with a e of 14. vas provided prior to the 116. d to follow infection			

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change gloves and wash hands when moving from a contaminated area to a clean area. The clinical record of Resident #4 was reviewed

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Facility ID: VA0406

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CENT	RTMENT OF HEALTH ERS FOR MEDICARE	HANT IMAN SERVICES & MEDICAID SERVICES		(,	PRINTED: 08/10/2016 FORM APPROVED
STATEME AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		JLTIPLE CONSTRUCTION DING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495409	B. WING		c
NAME OF	PROVIOER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	07/28/2016
ABING	DON HEALTH CARE LL	С		15051 HARMONY HILLS LANE ABINGDON, VA 24212	
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t a	7/26/16 and 7/27/16. to the facility 10/3/13 but not limited to Alzh dysphagia, gastroeso glaucoma, atheroscle gastrostomy, peripher hereditary and idiopat Resident #4's signification with an assessment refe/30/16 assessed the summary score of 10 c Summary Score. Furth change MDS revealed Status and more specifichere were "dash marking B. Support Providenark for height.	Resident #4 was admitted with diagnoses that included eimer's disease, anxiety, phageal reflux disease, rotic heart disease, ral vascular disease, and hic neuropathy. Int change in assessment eference date (ARD) of resident with a cognitive out of 15 in Section C her review of the significant in Section G Functional fically G0120 Bathing that s' for A. Self-Performance ed. Section K had a dash	F 4	41 Please refer to pag	e 46
ta th do W th dis ap cu rer	P.N. #4 placed a barried table. The other parties contained an ice contained an ice contained and ice contained and ice contained gloves and remo	ooler with Resident #4 's #4 washed hands, byed the old dressing, ied gloves and cleaned 's right ankle and ze. L.P.N. #4 then pre-dated with the L.P.N. #4 failed to			

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7/27/16 at 8:00 a.m.

The surveyor requested the facility policy on dressing changes from registered nurse #4 on

The surveyor reviewed the facility policy titled "Dressings-Clean Technique" on 7/27/16. The policy read in part "4. Wash your hands and

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DE	PARTMENT OF HEALTH	HAND(MAN SERVICES		(PRINTED: 08/10/2016
CE	NTERS FOR MEDICARI	& MEDICAID SERVICES		' ,	FORM APPROVED
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		495409	B WING	i	C
NAM	E OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	07/28/2016
ABII	NGDON HEALTH CARE LL	C		15051 HARMONY HILLS LANE ABINGDON, VA 24212	IF GODE
(X4) PRE TA	FIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF	ION SHOULD BE COMPLETION HE APPROPRIATE DATE
F 4	41 Continued From pag	e 49	F 4	41	
F 502	dressing, place in dishands. 7. Open pack reached area on a cleused. 9. Open and a Using a 4 x4, clean a inner to outer aspect discard 4 x 4. Use an Remove gloves. 12. non-sterile gloves. 14 dressing." The surveyor interview 1:30 p.m. The surveyor should be changed an after cleaning a wound clean dressing. L.P.N. changed gloves and w wounds. The surveyor informed the above concern duri meeting on 7/27/16 at 3	3:50 p.m. was provided prior to the 1/16.	E 500	Please refer to	
SS=D			F 502	F 502 Administration/La	abs
	The facility must provide services to meet the net facility is responsible for of the services.	e or obtain laboratory eds of its residents. The the quality and timeliness		 It is duly noted that have hemocult stool ordered on 6/7/16. 	
	This REQUIREMENT is by:			Any resident has the affected if labs are n ordered.	
	Based on staff interview review, the facility staff fa ordered laboratory tests (Resident #3). The staff hemoccult stool ordered	ailed to obtain a physician for 1 of 27 residents failed to obtain a		 Licensed staff have the importance of oldered for the been ordered for the beautiful as the process for the beautiful for the be	btaining all labs that for any resident as

physicians orders for labs.

CENTERS FOR MEDICARE & MEDICAL	N SERVICES D SERVICES		(PRINTED: 08/10/2016
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER IDENTIFIC	R/SUPPLIER/CLIA ATION NUMBER	(X2) MUI. A BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	95409	B WING		С
NAME OF PROVIDER OR SUPPLIER ABINGDON HEALTH CARE LLC (X4) ID SUMMARY STATEMENT OF DEFINER (EACH DEFICIENCY MUST BE PRECEDED.)	CIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE ABINGDON, VA 24212 PROVIDER'S PLAN OF CORRECTION	07/28/2016
TAG REGULATORY OR LSC IDENTIFYING I	NFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 502 Continued From page 50		F 50	2	
The findings included:				
The staff failed to obtain a hemoco ordered on 6/7/16 for Resident #3. The clinical record of Resident #3. 7/26/16 and 7/27/16. Resident #3 to the facility on 12/7/12 and readm 7/14/16 with diagnoses that include limited to unspecified intellectual dipneumonitis, status epilepticus, dyspipolar disorder, osteoporosis (age hypokalemia, sleep apnea, restless syndrome, anxiety, osteoarthritis, augastroesophageal reflux disease. Resident #3's annual MDS with an a reference date (ARD) of 11/17/15 coresident with a cognitive summary sof 15 in Section C0500. Resident #3 supervision of one person for toiletin A telephone order dated 6/7/16 read hemacult (sic) stool x1. Check iron, & folate.	was reviewed was admitted was a		The Unit Manager and/or designee audit lab orders and results daily (M x4 weeks, then weekly x8 weeks in a clinical meeting. Any discrepancies be addressed promptly and findings be reported to Quality Assurance committee for review and further analysis of findings. Correction date September 12, 2016	I-F) the will will
The surveyor located the results of the ferritin, B12 and folate levels but was locate the results of the hemoccult sto. The surveyor informed registered nur inability to locate the results of the phyon 7/27/16 at 1:30 p.m.	able to ool. se #1 of the /sician order			
The surveyor reviewed the progress n 6/7/16 and 6/8/16. There was no docuthat the stool had been obtained. The note dated 6/7/16 read to check the stool of the s	mentation physician			

with labs.

obtain the blood work ordered above. Follow-up

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 3 of 27 residents. (Resident #12, #17 and #19)

The findings included:

- Residents # 12 and #17 incomplete documentation of baths is noted. Bath schedules for both residents have been reviewed.
 - The incomplete documentation of recording Resident #19s blood glucose recheck in the medical record in an hour if blood glucose was > 500 was reviewed with LPN #5
- Any resident's medical record has the potential to be affected if there is incomplete bathing documentation or incomplete blood glucose documentation. Facility will audit to determine what residents have followup blood glucose orders for specific parameters to who else is potentially at risk.

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EvenI ID: SOHX 11

Facility ID: VA0406

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1 STATEMENT OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			FORM APPROVE OMB NO. 0938-039
ANO PLAN OF CORRECTION	IDENTIFICATION NUMBER	A BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDED OF CO.	495409	B WNG		С
NAME OF PROVIDER OR SUPPLIE			STREET ADDRESS, CITY STATE, ZIP CODE	07/28/2016
ABINGDON HEALTH CARE			15051 HARMONY HILLS LANE ABINGDON, VA 24212	
CACH OFFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEOED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D.DC (Vo)
F 514 Continued From p	200 F2		DEFICIENCY)	

F 514 Continued From page 52

The facility staff failed to document baths in the clinical record for Resident #12.

Resident #12 was readmitted to the facility on 3/16/16 with the following diagnoses of, but not limited to irregular heartbeat, high blood pressure. end-stage kidney disease, diabetes, depression, dysphagia, sleep apnea and gastrostomy. The resident was coded on the MDS with an ARD (Assessment Protocol Date) of 6/23/16 had a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #12 was also coded as requiring extensive assistance with 1 staff member for dressing and personal hygiene.

The surveyor conducted a review Resident #12 ' s clinical record on 7/27/16. It was noted that baths were not documented on 5/2/16, 5/9/16 and 5/19/16.

Unit Manager #1 was notified of the above documented findings on 7/27/16 at 5:45 pm by the surveyor.

On 7/28/16 at 1 pm, Unit Manager stated "We have looked at the Resident 's chart and we cannot find out why the baths were not documented. "

The administrator, director of nursing, assistant director of nursing and clinical services specialist were notified of the above documented findings on 7/28/16 at 3:15 pm.

No further documentation was provided to the surveyor prior to the exit conference on 7/28/16. F 514

- 3. Licensed staff will be educated regarding the use of Point Click Care (PCC) and documentation of baths given for each resident. Licensed nursing staff will also be educated on the importance of getting pertinent medical documentation such as blood glucose rechecks into the medical record to ensure it is complete and accurate.
- 4. The DON and/or designee will audit bathing schedules and blood sugar documentation where there are followup orders for specific parameters daily (M-F) x4 weeks, then weekly x8 weeks in the clinical meeting. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings.
- 5. Correction date September 12, 2016

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>IAIEME	N FOF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			FORM APPROV OMB NO. 0938-03
ND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER	A BLIILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
NAME	r ppo	495409	B WNG		С
NAME OF PROVIDER OR SUPPLIER ABINGDON HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE	07/28/2016	
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F 514	Continued From pag 2. The facility staff the clinical record for	failed to document baths in	F 514		
: :	limited to end stage rediabetes, thyroid diso pneumonia. The resimples (an assessment (Assessment Referent abung a BIMS (Brief I score of 15 out of a portion of the session dent was coded, on the protocol) with an ARD ce Date) of 4/27/16 as nterview for Mental Status		Please refer to page 52		
o th	by the surveyor on 7/28 on 7/23/16, 6/1/16, 6/4/	Resident #17 was reviewed 8/2016. It was noted that 116, 6/15/16 and 6/25/16 cumented for Resident			
ac	nit Manager#1 was no ocumented findings by 1 pm.	otified of the above the surveyor on 7/28/16			
α	n 7/28/16 at 2:30 pm, s like the other one. e baths were not docu	Unit Manager#1 stated, " We cannot find out why mented."			
spe	ector of nursing and th	f the above documented			

surveyor prior to the exit conference on 7/28/16.
3. For Resident #19, the facility staff failed to maintain a complete and accurate clinical record

DEPARTMENT OF HE CENTERS FOR MEDI	CARE & MEDICAID SERVICES		(PRINTED: 08/10/20 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II	TIPLE CONSTRUCTION	OMB NO. 0938-039
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ABINGDON HEALTH CARE LLC		- 1	STREET ADDRESS, CITY, STATE, ZIP COD 15051 HARMONY HILLS LANE	E
			ABINGDON, VA 24212	
THE TENTO TO THE TENTO	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRE	CTION
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F 514 Continued Fron	nage 54			
The facility nurs	ing staff failed to document the	F 51	4	
Residents BS in	the clinical record.			j
				1
08/28/15 Diagno	as admitted to the facility poses included, but were not	•		1
miniced to, demer	Ma. Chronic kidney discoss			
oraneres, attentis	l. [estless lea syndromo			
depressive disord	der, and diabetic neuropathy.		Please refer to many re	
Section C (coanit	ive patterns) of the Residents		Please refer to page 52	<u>′</u>
Significant change	In status MDS (minimum data			
2017 0226221116UL	With an ARD (accompan			
reference 09(6) Of	06/29/16 had a summary score sible 15 points. Indicating the			
vesidelit was alet	I and Drientated Section I		-	
(active diagnoses)	included the diagnosis of			1
diabetes.	-			į
The Residents clin	ical record included the			
ioliowing physician	orders ·			
BS (blood sugar) a	(every) AC (before mode) e			j
mellitus type 2).	of sleep) for DMII (diabetes			
Humalog insulin inje	ect as per sliding			
scale501-600≈25	Units Recheck BS in 4 hours to			
still greater than 500	notify MD (medical doctor).		•	
	dents eMAR (electronic			ĺ
medication applinist	(BillOtt records) indicated that			
rue stati tiau docume	enten that the Recidente DC			
was 555 on 0//27/76	at 2100 (9.00 n.m.) and was		RECEIVE	D
unable to locate any	1:30 a.m. The surveyor was information to indicate the			}
DC hade	acon to indicate (Ne		VIIC 77 2040	٠

BS had been retaken within 1 hour.

On 07/28/16 at approximately 11:00 a.m. the surveyor and LPN (licensed practical nurse) #5 reviewed the Residents eMAR LPN #5 identified AUG 24 2016

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DEPARTMENT OF HEAL	TH AND IMAN SERVICES		(PRINTED: 08/10/20
STATEMENT OF RESIDENCE	RE & MEDICAID SERVICES			FORM APPROVI
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
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ABINGDON HEALTH CARE L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 15051 HARMONY HILLS LANE	
(X4) ID SUMMARY ST.	ATEMENT OF DEFICIENCIES		ABINGDON, VA 24212	
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F 514 Continued From pa	ge 55			
	nts BS she stated she had and	F 51	4	
stated she wrote it (OWn in a notebook I PN #5			
reached to the side	of her medication cart and			
the Residents BS as	Inside she had documented sheing 216. LPN #5 stated			
ane always wrote ev	'ervthing down in this			
notebook so she cou	Ild reference it if needed			
part of the clinical rec	ersonal notebook and not		Please refer to page 52	
			page 52	
The administrative st	aff were notified of the			
inaccurate clinical red Residents blood suga	cord in regards to the			
survey team on 07/28	ars in a meeting with the 3/16 at approximately 3:15			
p.m.				
No further information	regarding this issue was]
provided to the survey	team prior to the exit			1
conference.				-
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F 000 Initial Comments		F 000			
was conducted 07/26 complaint was investi Corrections are requi CFR Part 483 Federa requirements and Viro	ginia Rules and Regularing Facilities. The eport will follow. O certified bed facility values. The survey. The survey satisfients with 23 current idents #1 through #20 losed record reviews in #24). I compliance with the exequirements:	ction One ey. h 42 ations Life vas ample t and			
Nursing Home Rules and	ith the following Virgin d Regulations:	ia			
12 VAC 5-371-360 A &E	cross-reference to F5	14	Cross-reference to F 514	page 52	
12 VAC 5-371-310B C	ross-reference to F502	2	Cross-reference to 502 p	age 50	
12 VAC 5-371- 220A cr	oss-reference to F309	e	Cross-reference to F 309		
12 VAC 5-371-250 (A.1 Ti Reference to F-272 12 VAC 5-371-250 (F, H, I F-280			Cross – reference F 272 p		
			Cross-reference F 280 pa	ge 20	
ORY OIRECTOR'S OR PROVIDER/SUPP	LIER REPRESENTATIVE'S S	IGNATURE	TITLE		
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12 VAC 5-371-300 (A F-425. 12 VAC 5-371-250 (G)				Cross reference to F 425 or Cross reference to F 279 or	
12 VAC 5-371-220 (B) 12 VAC 5-371-340 (A) 12 VAC 5-371-300 (J.3 12 VAC 5-371-180 (A.B F-441	Cross reference to F	-332 . -371.		Cross reference to F 332 on Cross reference to F 371 on	
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